TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Doctors Hospital at Renaissance

Respondent Name
New Hampshire Insurance Co

MFDR Tracking Number
M4-17-0532-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
October 25, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to TWCC guidelines, Rule §134.403 states that the reimbursement calculation used for establishing the MAR shall be by applying the Medicare facility specific amount."

Amount in Dispute: $177.08

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please the EOB's. The Carrier is in the process of re-auditing to determine whether additional payment is due to the provider. If the provider should receive the full amount it is requesting through medical dispute resolution, then the Carrier requests that the provider withdraw it request for medical dispute resolution."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 31, 2016	72070	$177.08	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P1 – P12 – Workers' compensation jurisdictional fee schedule adjustment

Issues

1. What rule applies to reimbursement?

Findings

1. The requester seeks additional reimbursement for $177.08 for outpatient hospital services rendered on March 31, 2016.

   The requestor states, "…there is a pending payment in the amount of $177.08." The respondent states, "The Carrier is in the process of re-auditing to determine whether additional payment is due to the provider."

   Neither party sent supporting documentation of an additional payment. Therefore, this review is based on information submitted at the time of the request for medical fee dispute resolution.

   As both positions are related to the appropriate fee, this review will consider the applicable fee guideline found in 28 Texas Administrative Code §134.403, "Hospital Facility Fee Guideline--Outpatient."

   The relevant portions are:

   > (b) Definitions for words and terms, when used in this section, shall have the following meanings, unless clearly indicated otherwise
   >
   > > (3) "Medicare payment policy" means reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.
   >
   > (d) For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section, including the following paragraphs.

   The resources that define the components used to calculate the Medicare payment for OPPS are found below:

   - **Payment status indicator** - The status indicator identifies whether the service described by the HCPCS code is paid under the OPPS and if so, whether payment is made separately or packaged. The status indicator may also provide additional information about how the code is paid under the OPPS or under another payment system or fee schedule. The relevant status indicator may be found at the following: www.cms.gov, Hospital Outpatient Prospective Payment – Final Rule, OPPS Addenda, Addendum, D1.
   - **APC payment groups** - Each HCPCS code for which separate payment is made under the OPPS is assigned to an ambulatory payment classification (APC) group. The payment rate and coinsurance amount calculated for an APC apply to all of the services assigned to the APC. A hospital may receive a number of APC payments for the services furnished to a patient on a single day; however, multiple surgical procedures furnished on the same day are subject to discounting. The relevant payment amount for each APC may be found at www.cms.gov, Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Annual-Policy-Files, Addendum B. These files are updated quarterly.

Review of the status indicators for codes submitted on the medical bill finds:

- 72070 – "Radiologic examination, spine; thoracic, 2 views." This code classified as Q1 or STV-Packaged Codes, (1) Packaged APC payment if billed on the same date of service as a HCPCS code assigned status indicator "S," "T," or "V."
- 72130 - "Computed tomography, thoracic spine; without contrast material, followed by contrast material(s) and further sections." This code has status indicator "Q3" or Codes that may be paid through a composite APC. However, since this is a single CT scan the composite does not apply. The single code APC found at www.cms.gov, Addendum M, is 5571. This APC has a status indicator "S."

Based on the applicable Medicare payment policy code 72070 is packaged when submitted with code 72130. Therefore, the Division finds no additional payment is due.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		January 31, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.